WFA-Outline

A. INTRODUCTION

B. CONTEXT AND DATA

First, I believe the funding and staffing for fraud activities needs to be clarified. There is often confusion surrounding the differences between *Provider related fraud* and *Recipient related fraud. (clarify what these are.)* My focus today is on recipient fraud activities and recipient collections.

I'd like to start by providing some context for fraud funding as it is beneficial to know where we've been to better determine where we are and where we can be.

1. In 2004, funding for recipient fraud was **$2,340,000.** By 2009, fraud funding decreased to **$561,892.**
2. This represents a **76%** decrease in fraud funding.
3. **At the same time, eligibility was greatly expanding. For example, the FShare program nearly doubled; and Badger Care was expanding as well.**
4. **Also at the same time, reporting was reduced to address the error rates.**
5. In 2009, **$7.2 Billion** in benefits were issued for CC, MA, BC, W2, FS, SC but only **$561,892** was contracted out for public assistance recipient fraud efforts. This represents **.008%** of issuance.

Another way to look at program integrity efforts on the recipient end is to compare them to efforts for Provider related fraud in the MA and CC programs.

6. MA Provider Fraud State staff, = **30**. CC Provider Fraud State staff = **30**. State Recipient Fraud staff = **3**. (There are other people, but not entirely dedicated to oversight of recipient fraud. Various state staff contribute through finance, policy, contracting within the program areas)

7. MA Provider Fraud state staff are responsible for monitoring approximately 60,000 Providers (medical providers, clinics, medical device sales, double billing; CC Provider staff are responsible for monitoring approx. 2,203 Providers or those providing the child care services; Recipient fraud staff for are responsible for over **2 Million cases**. (I should note that these may be combined program cases.)

8. This is not exactly apples to apples, as most of the fraud efforts for the recipient end are handled at the local agency level through the contracting, but the data does demonstrate how little state oversight there is for recipient fraud.

9. This year, DHS contracted out $500,000 dollars for FShare and MA, BCare recipient fraud. That represents an average **$6400** per county. Agencies with low caseloads get a minimum of **$67** for fraud efforts.

10. For DCF's CC recipient fraud efforts, it gets a bit more complicated as the fraud dollars allocated for this year, **($545,000)** actually includes recipient AND provider fraud efforts as agencies are to use general administration dollars to cover additional program integrity costs.

11. For the CC dollars, the average dollars received per county are **$6900**. The lowest amount allocated is **$102.**

**So an agency with a small caseload could get less than $200 in recipient fraud funding.

FEV SECTION

Earlier comments to the commission explained how the current recipient fraud dollars are being used to focus on fraud prevention. In fraud program terms we would use a FEV or the Front-end Verification Process to make sure dollars are going out correctly.

A FEV is defined as finding errors at application or review, so stopping benefits from going out. **This sounds great!** Stop everything incorrect from going out thereby saving a lot of effort finding it on the back end. Although FEV's or fraud prevention in general is **integral** to program integrity efforts, there are limitations.

First, because FEV's are only being done on a small percentage of the caseload.
I refer you back to the decrease in fraud funding which includes FEV services (actually DHS has clearly stated that the primary focus for the funding is prevention through FEV's or "Pre-certification investigations".)

A further distinction should also be made between FEV's and basic eligibility determinations.

1. FEV's are ONLY done by referrals to a fraud worker when an error is suspected.

2. General eligibility determinations happen on every case and are focused on making sure ABCD are submitted. Not necessarily if what is submitted is correct.

FEV's go through and actually take extra steps to verify the information.

I should note that verification of data is done concerning wages, identity, etc. in general eligibility-- but caseloads are high and there is a limited time to process a case. (30 days from date of application regardless if all information was provided; and, within the calendar month from the review.)

a. **Something to illustrate this point better:** recent attendees of a conference were told that 3 workers processed 90,000 Senior Care applications as an example of efficiency. But no claims have ever been established in the SC program since the collection functionality was added in 2006.
b. **So not ONE incorrect case in over 5 years?**

c. If the focus is on the front-end, and we can stop incorrect benefits from going out, how can 3 workers process 90,000 applications and be focused on verification?
d. The focus is clearly getting benefits out. **And it should be!** But without a strong integrity program, eligibility guidelines are meaningless.

The Second limitation to stopping benefits from going out incorrectly is that the majority of fraud is a result of 2 things:

*incorrect household composition AND
*unreported income

And very few of these would be caught before benefits were issued.

Public Assistance fraud is not sophisticated. We know what it looks like.

Let me provide an example of why a general eligibility determination will not find a household composition case.

EXAMPLE: Jane Doe applies for benefits and provides all required documents. All the information she provides is correct in respect to income, identity, etc. EXCEPT she omits the father of her children is living in the home w/ income that would make them ineligible for benefits.

Because the information provided was accurate, this case would never have been referred for a FEV, thus the fraud would not be detected.

Another common reason for fraud is disparity in income between what is reported vs. actual income. It is very common to have:

a. Falsified income reporting, as verification of wage forms are given to the recipient to fill out. They are routinely just filled in to meet eligibility guidelines and signed by the recipient as the supervisor.

And, because of caseloads and priorities, many data matches are just deleted. If the "verification" is on file, it meets the requirements for eligibility and the worker moves on.

I get numerous fraud tips alleging that co-workers or exes are falsifying income and hours to receive CCare, FS, BC I will review the case and clearly see that the reported wages from Unemployment Insurance are much higher than the reported income, and the information is clearly there, but not acted on.

It is not unusual to find a case where a recipient falsified an income verification and was caught. Then for the same person to come back and falsify income and employment again. The document is just accepted. ABCD.

I also routinely have cases where recipients are:

b. Forging paystubs
c. Not reporting new jobs
d. Unreported property with rental income
e. Self-employment cases where assets are not in line with income--

Self-employment is especially tricky, as the means to verify income is self-declared. The process requires a <u>self-employment income report</u> or a copy of the Schedule C from the previous tax year.

However, a Schedule C form can be obtained on the internet and filled out to meet eligibility guidelines. It does not mean that it is an official, filed tax document.

I just recently had a case where the BCP recipient owns a $500K home; owns his own business, nice high-end cars, etc. All self-reported income.

Of course assets are mostly not counted for eligibility, but <u>continuing assets are a tip-off to unreported income.</u> He just made himself, his wife, and his 3 children eligible for BC by falsifying reporting which put him under the income limits.

This case would never have been found in a general eligibility determination. The question would have been: Do we have ABC and D? Do we have a schedule C? Check. All is correct.

The Third limitation to relying on FEV's ---is that a FEV's will only occur by a referral from a case worker who suspects an error.

This is problematic because no supplemental training on how to identify an error prone case, or establish a claim has been provided by the State for a decade besides individual sessions offered at conferences; **and a small module in new worker training.** So we are relying on general eligibility determinations to find errors.

There are also just general issues and <u>misunderstandings</u> about collections as well:

For example:
There are 3 error types assigned to overpayment claims when they are established for collection:

1. Non-client Error- a keying error
2. Client error: the recipient failed to report something that affected their benefit level or eligibility, but it was just an error, no intent to defraud, they just didn't understand
3. Fraud: This must be adjudicated in some way- in a criminal court or through an administrative process

The DHS report to the Joint Finance Committee on Food Share fraud concluded that coding of claims shows that most of the client error claims are unintentional.

The fact that fraud coded claims are decreasing while client error claims are increasing does not mean there is less fraud—or that the client error claims were unintentional. Instead, as the fraud programs were being defunded and the local agencies were told to concentrate on the front-end –fewer agencies had any resources to prosecute fraud- so all of the fraud claims were coded as client error.

Let me provide
Some examples of client error:

1. Falsifying a wage document is considered a client error.
2. Not reporting the father of your children in the household with income that would make you ineligible for benefits is considered a client error
3. Forging employment records to make yourself eligible is a client error.

As an aside, and another thing that is misunderstood—These are not small amounts! One recipient can easily defraud the various programs of $50K or more in one year.

These examples illustrate the deficiencies of focusing solely on prevention. A successful integrity program requires both a front-end and back end approach- and, it requires training on how to identify cases that are error prone and training on how to establish claims. General Eligibility determinations are not sufficient to stop improper payments from going out.

COLLECTIONS SECTION

Recipient fraud contract funding has a direct impact on claims establishment and collection revenue.

From 2008-2009

FS claims decreased 26%
CC recipient claims decreased 41%
MA claims decreased 23%

Actually, the MA/ BC programs were the most affected, as claims decreased a total of **68% over 3 years**- all while the programs were expanding.

Overpayment collection can provide additional revenue by collecting improper payments that should never have gone out; and, that we would never otherwise got back.

1. At the first WFA meeting, a representative from DOA indicated there was a Medicaid Gap of over $100 Million. Instead of reducing benefits or adding waitlists we should enforce the current eligibility guidelines by detecting more errors/ fraud and establishing overpayments for collection. The money collected could be used for those who are eligible.

<u>This point is important as what gets established gets collected.</u>

2. **We have an overall collection ratio of 81.15 % at the 9-10 yr mark.** *(Page 7)*

   The ratio is the amount collected vs. the amount of receivables available for collection. So for every $1 established as an improper payment, .81 is collected.

HOW WE DO COLLECTIONS
-Quick overview on how we collect these dollars. Lien, levy, tax intercept, recoupment, vol pay.

So again, if there is adequate funding, this process will pay for itself and create revenue. One of the problems is determining the correct level of effort and funding for fraud efforts. This is difficult, as we know these are excellent programs that help our most vulnerable. But unfortunately, there are also many people defrauding the system.

Now some contend the level of fraud/ improper payments is 10% or higher in any program—but to simplify, and to help understand what funding would create, I determined a base level of 1% improper payments.

Using 2009 data for benefits issued of $7.2 Billion (all programs)
1. **You could expect $72 million in claims established.**
2. **Applying the average collection ratio at the 9-10 year mark, we would collect $58 Million dollars.**

In the data packet I provided, I show actual claims created by workers to determine an average of claims one worker can establish in a year.

1. Using an average of claims established per worker, one worker would net revenue in excess of wages of $4 Million over 10 years.
2. 20 workers establishing claims would net revenue in excess of wages of $80 million over 10 years.

We have already shown tremendous success with our increased focus on Child Care Providers. DCF has demonstrated estimated savings of over $100 Million since ramping up fraud efforts.

DHS has a successful MA Provider Fraud unit in cooperation with DOJ.

Even with limited funding on the recipient end, DHS has indicated their preliminary data results show the fraud program is resulting in a 1:20 cost savings, or for every $1 we spend on program integrity efforts we get $20 in savings.

So the dollars invested have been proven to be cost effective time and time again; both in dollars saved and dollars collected.

There are also intangible results like deterrence. I can guarantee that Providers have spread the word around the state that DCF is combating fraud, and data supports this. The same would happen if we make efforts to combat recipient fraud.

We are looking at an increase in caseload as the economy has slowed down. And the new Federal Health care law will make more people eligible for Medicaid. **By necessity** we are moving toward a centralized case processing model. But we have an example in Senior Care showing that centralization of processing can be problematic as far as finding improper payments.

As caseloads are increasing and processing is centralized, and verification is limited—it is NOT the time to defund program integrity.

The very purpose of eligibility limits is to use a limited amount of funding to help the most people possible, who are the most in need.

The citizens of WI support these programs with their tax dollars and have a right to expect that only those who are eligible are receiving the services and the state is administering their dollars correctly.

In Closing- We need to take a realistic approach to recipient fraud. We need to determine the proper level of effort to combat this fraud -- AND FUND IT.

If we do, it PAYS FOR ITSELF, returns improperly spent revenue, has a deterrent effect, and helps to ensure the right benefits go to the right people at the right time.